# Health Care Alternatives for Reservation 13 and Eastern Washington

## Report of the Mayor's Health Care Task Force

August 1, 2006

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### Task Force Members

Gregg A. Pane, *Chairman; Director, District of Columbia Department of Health*

A. Cornelius Baker, *Community Health Advocate*

Michael M. Barch, *Chairman of the Board, Healthcare Council of the National Capital Area*

Sharon Baskerville, *Executive Director, District of Columbia Primary Care Association*

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Colene Daniel, *President and CEO, Greater Washington D.C. Region for Doctors Community Healthcare Corporation; CEO, Greater Southeast Community Hospital*

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Eric Rosenthal, *Co-chair, Health Committee, Hill East Waterfront Action Network*

K. Edward Shanbacker, *Executive Vice President, Medical Society of the District of Columbia*

Bailus Walker, Jr., *Chairman, Mayor's Health Policy Council*

Richard N. Wolf, *President, Capitol Hill Restoration Society*

***Acknowledgements***

*The Task Force would like to thank the experts who gave generously of their time in preparing presentations for the Task Force, attending Task Force meetings, and responding to members' questions. The Task Force's deliberations were greatly enhanced through the participation of these experts. Special appreciation is extended to experts from outside the District, who came on short notice and brought outside perspectives into a local discussion.*

*The Task Force would like to express its appreciation to the staff of the Department of Health for their administrative and logistical support and to the staff of the Department of Health, Health Professional Licensing Administration, for hosting the Task Force meetings and assuring that each meeting ran smoothly.*

GOVERNMENT OF THE DISTRICT OF COLUMBIA

August 1, 2006

The Honorable Anthony A. Williams
Executive Office of the Mayor
John A. Wilson Building
1350 Pennsylvania Avenue, NW
Washington, DC 20004

Dear Mayor Williams,

The Health Care Task Force is proud to submit our report, *Healthcare Alternatives for Reservation 13 and Eastern Washington.* In fulfillment of your Order to us, dated April 19, 2006, we have presented reasonable alternatives to the original NCMC proposal for further consideration by you and other policymakers.

This report reflects the contribution of all 17 Task Force members. We met during nine half-day sessions starting May 2nd, and attendance was excellent. Proceedings were open and fair, and discussions were lively and well informed. The resulting report covers each and every element of your charge to us, some understandably in more depth than others, given the compressed timeframe allowed.

We have set out the results as briefly as possible, consistent with clarity. As you requested in our meeting of July 12th, our report indicates areas of agreement, areas of disagreement, and where further work is needed to assess alternatives and plan for successful implementation.

The record of our deliberations is completed by a detailed set of appendices. It lists all documents distributed to Task Force members, plus those made available to the Department of Health by yourself and other members of your Administration.

My personal thanks go not only to the hard-working members of the Task Force, but also to staff, and to the experts who presented in meetings, including a number from Howard University. We trust that this report will be useful to you as you continue to strive to serve all residents of the District of Columbia.

Sincerely,

Gregg A. Pane, MD, MPA
Chairman, Mayor's Health Care Task Force
Director, D.C. Department of Health

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# Executive Summary

The Mayor's Health Care Task Force hereby fulfills its purpose by advising District policymakers on alternatives to improve District residents' health and the health care presence in eastern Washington.


### The Charge

The Task Force has responded to the Mayor's charge[1] by:

- reviewing types of health care facilities appropriate for Reservation 13 and examining alternative approaches to best meet community needs;
- identifying the District's most pressing health issues;
- considering ways to promote financial stability of District hospitals;
- considering improvements in emergency medical services; and
- examining ways to allocate disproportionate share dollars and Diagnosis-Related Group payment weights to improve equity and appropriateness of use of these funds.

By Mayoral directive, the Task Force was chaired by Dr. Gregg A. Pane, Director of the Department of Health, and included representatives of hospitals, clinics, physicians, advocates, experts, and the community at large. The Task Force approached its work in phases:
(1) consideration of needs,
(2) presentation of alternatives,
(3) discussion and debate on proposals,
(4) Task Force recommendations, and
(5) conclusion and next steps.

[1] The full text of the Mayor's charge, summarized here, is provided in the appendix.

### The Process

Throughout, the process was open to all views and proposals. The Task Force brought together prior proponents and opponents of the full-service hospital model and included others with varying perspectives.

Deliberations considered all alternatives proposed, and the record was open for submission of documentation by all parties as well as the Department and staff. Howard University chose not to serve on the panel but made a detailed presentation of its proposal.[2] In addition, all Task Force materials were sent to Howard University representatives. GSCH made a presentation and also served on the panel.

The Task Force met in nine half-day sessions over two and a half months. Sessions featured thirteen expert presentations and collegial discussion on all relevant issues. The accelerated time frame necessitated considering some matters in less depth than others.

At the July 11th meeting, members agreed on the alternatives to be forwarded to policymakers, and staff were directed to draft this report. The draft report was then circulated by email to all Task Force members for review and comment. Through this process, many items were agreed upon.

[2] Howard University's letter regarding Task Force participation as well as all other materials distributed to the Task Force are listed in the appendix. Copies of these materials will be made available on the D.C. Department of Health's website.

*The panel recognized three key types of health needs:*

- to improve residents' health status, which is affected by high rates of HIV/AIDS, hypertension, diabetes, obesity, and other chronic conditions, as seen in morbidity and mortality statistics;
- to assure that the most needed services are accessible from locations in eastern Washington; and
- to improve integration and efficiency of services across the continuum of care, notably including the interface of emergency and other services.

In crafting alternative ways to address those needs, Task Force members focused on how to spend a one-time fund of $212 million. This amount is the previously agreed ceiling on the District's half of construction costs for the National Capital Medical Center (NCMC). It was recognized, however, that any facilities built with such funds would need to attract ongoing funding to be sustainable. Disproportionate share payments, the DOH budget, or other funds might contribute.

Moreover, although health prevention or improved lifestyle choices have an even larger impact on health than do health services, one-time funding for them would also need supplementation to maintain ongoing effectiveness. Finally, additional expansions of insurance coverage, which are known to improve health, were generally seen as desirable—but beyond the mission of the Task Force.

### Framework for Decisions

After long discussion of a variety of options, the Task Force agreed that four sets of investments constituted plausible alternatives for consideration in the District. (A table providing more detail on each of the four alternatives deemed plausible is found at the end of this executive summary.)

*The first two options would invest all or almost all funds in additional or improved capacity at hospitals:*

1. NCMC-enhanced: Elements would be added to the original proposal, at no cost to the District, to better integrate NCMC into the community and existing public programs.
2. GSCH renovation and expansion: Renovation of GSCH would add staffed beds and upgrade trauma capability; remaining funds would be invested in other healthcare system infrastructure to promote disease prevention and system efficiency and quality. A variant would invest less at GSCH and add more ambulatory care capacity in eastern Washington, including an ambulatory care facility on Reservation 13.

*The other two options would invest the bulk of the funds in ambulatory care and health care system improvement:*

3. Healthplex at Reservation 13: A comprehensive ambulatory care facility (healthplex[3]) would be sited at Reservation 13 and additional ambulatory care facilities located in eastern Washington. Less extensive renovation would occur at GSCH, including added ambulatory care capacity. Remaining funds would be invested in other healthcare system infrastructure to promote disease prevention and system efficiency and quality.
4. Ambulatory care and other components: Investment would not be

[3] See note 6 of the table below for a description of the healthplex concept.

made in hospital capacity but in one or two new ambulatory care facilities, with possible expansion or enhancement of existing ambulatory care facilities. Substantial remaining funds would be invested in other healthcare system infrastructure to promote disease prevention and system efficiency and quality.

There was no support for investing in a smaller new hospital, such as a 50-bed urban facility.

Each of the four plausible options was designed to total $212 million. Dollar amounts were understood to be estimates. The appropriate size of investment is to be determined by assessed need and after due diligence review of fiscal projections. Residual funds are to be reallocated to other components.

*There was substantial agreement on several cross-cutting recommendations:*

- A broad study of emergency care and transportation is needed, as it is not clear which of many interrelated factors is most responsible for system problems, nor what intervention(s) would be most productive;
- GSCH should receive District funding only with a change in ownership and governance structure under a transparent process resulting in not-for-profit status;
- Facilities should be sized and sited based on needs data;
- Facilities should be located in the eastern part of the city, with particular consideration given to facilities at Reservation 13 and east of the Anacostia river;
- Services at each facility should be customized to neighborhood need.

### *Final recommendations*

There was panel support for each of the four options. Consensus was not achieved on which package of investments constitutes the best single option.

*In a final roll-call vote on the top two alternatives, Option 3 (healthplex and additional ambulatory care emphasis) was favored over Option 1 (enhanced NCMC) by a count of 10 to 5. The Chairman did not vote, and two members were absent. In its vote, the Task Force did not distinguish between Options 3a and 3b, presented in the table below.*

The Task Force consciously did not seek to address final design and implementation issues, citing the limited time available for its work. The options are presented as concepts that address the largest needs. Final investment parameters, associated business plans, and other details remain to be appropriately developed under principles outlined later in this report.

## Health Care Alternatives for Reservation 13 and Eastern Washington

| Proposals | Components of Proposals: Hospital investments | Investments in improved access to ambulatory care | Other infrastructure and investments in prevention, system quality and efficiency |
|---|---|---|---|
| ***Proposal already under consideration*** | | | |
| NCMC<br>total = $212 million | includes:<br>- full-service medical center<br>- 24/7 ED with level I trauma<br>up to $212m[1] | proposal includes:<br>- physician office complex on Res. 13<br>- outpatient surgery<br>$0m[2] | - medical research facility on Res. 13[2]<br>- state-of-the-art throughout, including IT<br>- links with community clinics<br>$0m[2] |
| ***Alternative proposals from Task Force*** | | | |
| 1. NCMC, with additions to help integrate into community<br>total = $212 million | same as original plus, e.g.:<br>- behavioral health beds<br>up to $212m[1] | same as original<br>$0m[2] | same as original, plus, e.g.:<br>- IT links w/ community providers & govt services<br>- EMS training and disaster preparedness<br>- community advisory board<br>$0m[2] |
| 2. GSCH major renovation and expansion[3] | a. full renovation, including:<br>- expansion of staffed beds<br>- upgrade to trauma level II<br>up to $188m[4] | proposal includes:<br>- ambulatory care walk-in clinic<br>$0m | modest investment in systems improvements[5], e.g.:<br>- ED/EMS study<br>$14m (or balance of $212m) |
| | b. lesser renovation, with focus on areas of highest assessed need<br>up to $120m[4] | - HealthPlex[6] at Reservation 13<br>up to $50m | signif. investment in systems improvements[5], e.g.:<br>- above plus grants for, e.g., electronic health<br>$42m (or balance of $212m) |
| 3. HealthPlex[6] at Res. 13 (plus lesser renovation for GSCH & new ambulatory care center) | partial renovation of existing GSCH facility, new ambulatory care clinic, some upgrade of trauma capabilities | a. HealthPlex[6] at Reservation 13<br>- renovation of and co-location of specialty care in existing CHCs[6]<br>up to $80m | significant investment in systems improvements[5]<br>- above plus, e.g., non-EMS medical transit system<br>$52m (or balance of $212m) |
| | | b. 2 ambulatory care clinics (Res. 13 & Ward 7)<br>- renovation and/or expansion of existing clinics<br>up to $132m | minimal investment in systems improvements[5]<br>$0m (or balance of $212m) |
| 4. Ambulatory care and other components<br>total = $212 million | - no hospital beds<br>$0m | - one or two ambulatory care centers sited and sized to meet identified needs<br>- consideration of expanding and enhancing existing primary sites rather than building new[7]<br>up to $80m | large investment in prevention, improved systems operations[5], e.g.:<br>- electronic health records<br>- smoking cessation<br>$132m (or balance of $212m) |

*General notes:*

Total costs to the District for any facility investment depend upon the cost-sharing arrangements with owner of facility.

The listing of any facility or any other investment as an option is separate from any decision about the facility's ownership or ongoing operations. Howard University, GSCH, and any other current or new health care provider could be considered as partners in any investment undertaken by the District.

Dollar amounts are estimates by proponents or staff. The appropriate size of any component investment is to be determined by assessed need and after due diligence review of its fiscal projections; residual funds are to be reallocated across the remaining components.

Investments in facilities all require ongoing funding for sustainability. Funding sources for consideration include DSH allocations, DOH budget, and other funds.

Some public health and/or EMS functions could also be shifted to Reservation 13 using operating funds only.

*Specific notes:*

1. $212 million is the agreed ceiling on direct District cost for half of the medical center portion of NCMC (including contingency funds)

2. Howard has agreed to pay full costs of associated physician office complex, research facility

3. District investment in GSCH assumes not-for-profit status for GSCH.

4. District cost does not include site acquisition costs, if any.

5. Other potential components might include, but are not limited to: study of emergency department utilization, trauma transport, and EMS issues ($1-2m); smoking cessation programs (up to $14m); prevention grants ($10-$30); diabetes and asthma management grants ($TBD); healthcare system quality and efficiency initiatives ($TBD); new non-EMS transit system ($3-$5m); electronic health records ($20-40m).

6. A Healthplex includes such services as emergency care, primary and specialty care physician offices, ambulatory surgery, diagnostic imaging, laboratory, and health education. Formal partnership(s) with hospital(s) provides ready access to care for patients needing more intensive treatment.

7. Other investments in ambulatory care might include, but are not limited to: freestanding ER ($8m); feeder or satellite clinics linked to partner hospitals ($5-16m each); embedded clinics (e.g., Minute Clinics) in high foot-traffic areas ($1-3m each); renovation of existing primary care capacity (up to $40m); development of specialty capacity (e.g., "circuit riding") at existing clinics ($50-100,000 each).

# Task Force Context

One important backdrop for this Task Force is the District of Columbia's long history of supporting health care for the underserved. Reservation 13 in eastern Washington played a key role as the location of the former D.C. General Hospital (DCGH), formerly the city's only public hospital (Figure 1). Reorganizations of DCGH occurred in the 1980s and 1990s before the facility's inpatient services were closed in 2001. DCGH was initially succeeded by continued operation of urgent and ambulatory clinics at Reservation 13, together with new D.C. Alliance health coverage for low-income residents.

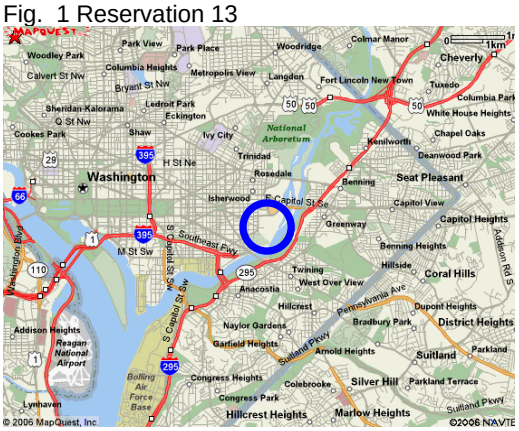
The Alliance provides comprehensive contracted services at multiple sites citywide. While the Alliance has a number of accomplishments, the city still lost a tangible "symbol" of its "commitment to D.C. residents," in the words of the Administration's July 2005 "National Capital Medical Center Proposal."

After federal transfer of Reservation 13 to the District in October 2002, the Council approved a Draft Master Plan that called for a new inpatient facility there. In November 2003, the Council directed the Mayor to negotiate with Howard University to build such a hospital. This led to the final plan for the National Capital Medical Center (NCMC) to construct a major new, state-of-the-art teaching hospital with associated ambulatory and research facilities to serve eastern Washington and the metropolitan area.

Final NCMC plans are described in the July 2005 proposal, the January 2006 Exclusive Rights Agreement, submissions to Council in February 2006, and a presentation to this Task Force in June 2006. (The appendix provides an annotated list of all documents formally considered by this Task Force.)

Another key backdrop for the Task Force is continuing concerns about emergency medical services (EMS) and backlogs in hospital emergency departments (EDs). Controversy about ambulance and other EMS services under the Fire and EMS (F/EMS) Department predated the loss of DCGH inpatient care, but intensified thereafter.

Fig. 1 Reservation 13



Staff graphic

The June 2006 Inspector General's "Special Report on the Emergency Response to the Assault on David E. Rosenbaum" in January 2006 suggests some citywide shortcomings. National news accounts and three June 2006 reports from the Institute of Medicine (IOM) highlight ED problems that are national in scope.

There is concern as well for the high rates of chronic disease, morbidity, and premature mortality seen in the District.

In April 2006, Mayor Anthony Williams announced that he wanted a task force "to examine the National Capital Medical Center (NCMC) proposal and to review whether there are alternatives to improving health care in a way that is fiscally sound," in the words of a press release (April 19, 2006). The Mayor subsequently constituted this Task Force and by Mayoral Order issued its formal charge.

# Summary of the Mayor's Order

The Mayor's charge to this Task Force was issued as an Order effective *nunc pro tunc* to April 19, 2006 (full text in appendix). It directed the Task Force to consider a number of specific issues while developing feasible alternatives to the full-service hospital already under consideration on Reservation 13:

- Improve the city's health care presence in East Washington
- Identify the District's most pressing health care issues
- Develop recommendations to promote the financial stability of all existing District hospitals
- Improve emergency room infrastructure
- Shore up the financial viability and quality of services at Greater Southeast Community Hospital (GSCH) in tandem with ensuring the continued stability of Howard University Hospital
- Examine the use and allocation of Disproportionate Hospital Share (DSH) dollars and Diagnosis-related Group (DRG) payment weights for District hospitals

Task Force deliberations sought to develop alternative investments in packages estimated to cost $212 million each. This sum is the ceiling on the District's share of construction costs for the proposed NCMC.

# Composition of the Task Force

To accomplish these tasks, the Mayor invited healthcare stakeholders to participate in the Task Force.[4] The resulting initial composition of the Task Force was criticized by some as imbalanced, with more positions having been accepted by stakeholders who had already taken a public position against the proposed NCMC than those who had come out publicly in support of the proposal.

In response, the Mayor sought and was able to identify additional stakeholders who represented both those who publicly favored the proposed NCMC and those who were knowledgeable but neutral on the proposal.

Task Force members represented a range of District residents and stakeholders with long experience in health care, including:

- Hospitals
- Physicians and clinics
- Community health advocates
- Health policy experts
- Community representatives

Howard University was invited to join the Task Force but declined to participate.[5] Key officials at Howard University were kept informed of the proceedings of the Task Force through inclusion on the distribution list for the minutes of each meeting. Howard University officials accepted an invitation to give a presentation on the NCMC to the Task Force and chose the June 27 meeting for its presentation.

[4] The Department of Health contracted with The Urban Institute to augment its own personnel in staffing the Task Force. A full list of Task Force staff is provided in the appendix.

[5] Howard University's letter regarding Task Force participation as well as all other materials distributed to the Task Force are listed in the appendix. Copies of these materials will be made available on the Department of Health's website.

# Task Force Process

## *Meetings*

The Task Force met every Tuesday afternoon between May 2 and July 11 (except May 30 and July 4) in the Health Professional Licensing Administration's conference room. All nine meetings were open to the public with the exception of a one-hour executive session at the third meeting to discuss the steps to be taken to reach consensus. Sessions were taped.

Minutes were issued after each meeting and distributed to Task Force members as well as to other stakeholders who had expressed an interest, including Howard University. The decisions made during the executive session were included in the minutes for that meeting. The minutes of each meeting were subsequently approved by the Task Force.[6]

At the first meeting, the Chair recommended and the Task Force agreed on the broad outlines of the Task Force's work (box below[7]). The key goal was to identify plausible alternative ways to invest the available $212 million to address the healthcare needs of District residents.

The Task Force agreed to allot the first third of the meetings to establishing a shared consensus of the health and healthcare needs of the District, with particular reference to the eastern part of the city. The second one third of the meetings were to discuss plausible alternatives to meet these needs. The final meetings were to debate the proposed alternatives.

**GIVEN THE MAYOR'S CHARGE AND THE NEEDS DATA, WHAT ARE PLAUSIBLE ALTERNATE HEALTH DELIVERY OPTIONS FOR THE COMMITTEE TO POTENTIALLY ADOPT?**

The Chair noted that the constrained time schedule for the Task Force's deliberations would not allow consideration of all issues. The Task Force agreed that further work could be undertaken, at the direction of the Administration, after the submission of the Task Force's report to the Mayor.

[6] The appendix provides a link to meeting agendas and minutes.

[7] This summary of the Chairman's charge to the Task Force was used as a wall poster for subsequent meetings. So were most of the other graphics in this report.

## Materials Considered

Staff provided written materials to all Task Force members—and some other interested parties—prior to each meeting. When requested, follow-up materials were also sent out about issues raised in each session. Members were asked to share documents that they felt would contribute to the discussion as well, and these were routinely distributed by email or in hard copy.[8]

Written materials were supplemented by expert presentations. Staff identified presenters who were expert in their fields, knowledgeable about urban health care contexts like the District of Columbia, and neutral with respect to proposed solutions. Some Task Force members and other local stakeholders also made presentations. Accompanying materials were also sought out and distributed.

These presentations—13 of them in all—significantly informed Task Force deliberations (box below). Some discussions were continued in follow-up exchanges of materials.

Presentations to the Task Force

- District of Columbia: Health Status, Trends and Risk Behaviors. John Davies-Cole, Bureau of Epidemiology and Health Risk Assessment, D.C. Department of Health
- Baseline Health Assessment of Low-Income D.C. Residents. Sara Rosenbaum, Department of Health Policy, George Washington University School of Public Health and Health Services
- Influence of Health Services and Other Factors on Health. Randall R. Bovbjerg, Health Policy Center, The Urban Institute
- Trauma Resource Allocation—Policy Issues and TRAMAH Model. Charles Branas, Department of Epidemiology, University of Pennsylvania
- District of Columbia State Health Plan. Mark Legnini, Healthcare Decisions Group
- Public Health Solutions to Urban Health Problems. Steven Woolf, Virginia Commonwealth University
- Recap: Summary of Needs and Priorities, Next Steps. Randall R. Bovbjerg and Barbara A. Ormond, Health Policy Center, The Urban Institute
- Emergency Medical Services in the District. Amit Wadhwa, D.C. Fire and Emergency Medical Services
- Components of the NCMC. Barbara A. Ormond, Health Policy Center, The Urban Institute
- Medicaid DSH Program: Current Structure and Opportunities for Change. Teresa Coughlin, Health Policy Center, The Urban Institute
- Greater Southeast Community Hospital—Sustainable, Quality Health Care. Colene Daniel and Pedro Alfonso, Greater Southeast Community Hospital
- Howard University and the National Capital Medical Center. Victor Scott, Howard University
- Status of Tobacco Financing. Marcy Edwards, D.C. Office of the Chief Financial Officer

[8] Presentations are included in the list of materials distributed in the appendix. Copies of presentations will be made available on the D.C. Department of Health's website.

# Task Force Discussion of Needs and Problems

The compressed schedule of the Task Force did not permit full consideration of all issues. The presentations and the background readings provided a shared level of knowledge about the issues. Combined with the wealth of individual knowledge of Task Force members, the approach allowed for an in-depth discussion of the issues.

Discussions typically led to a shared assessment of issues, although not always. Notably, members felt that more information would be required on trauma care capacity and EMS issues before a decision could be reached on the roots of the problems and possible solutions.

Task Force deliberations ranged broadly over the relevant topics (box below). The balance of this section covers each of these areas in turn.

Needs and Problems Discussed by Task Force

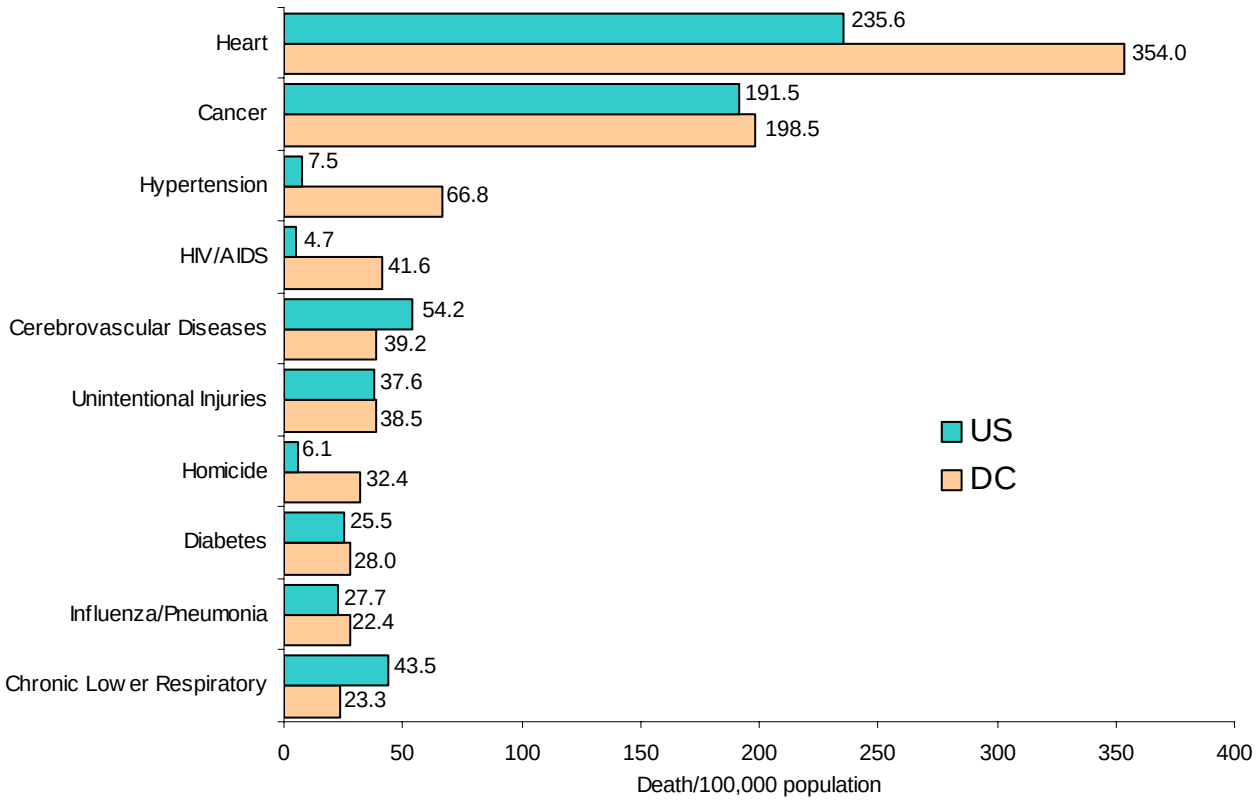
- Health Status of District Residents
- Health Care Services: Availability and Gaps
- Emergency Services Issues
  - Trauma Care Capacity
  - EMS and Emergency Department Issues
- Financial Stability of Existing Hospital Capacity
- Available Financing
- Hospital Payment Issues
  - Disproportionate Share Hospital Funds
  - Diagnosis-Related-Group Payment Weights
- Additional Issues Noted

## *Health Status of District Residents*

The Task Force considered the health profile of District residents—overall and by geographic and demographic criteria—within the context of the federal/state *Healthy People 2010* goals. These goals had been incorporated into the draft state health plan presented to the Task Force.

Available data show that hypertension, HIV/AIDS, heart disease, cancer, and diabetes are the leading causes of morbidity and mortality in the District. Rates of HIV/AIDS and hypertension are higher than in the country at large (Figure 2). The District compares more favorably to other large cities, as shown by the compilations of the Chicago Health Department.

Fig. 2 Ten Leading Causes of Death in the District of Columbia, 2003
(age-adjusted death rates)

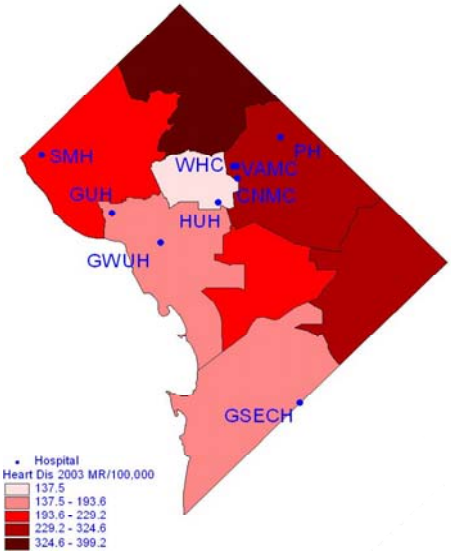



Source: Davies-Cole presentation, using data from District of Columbia State Center for Health Statistics, CDC, and NCHS
Note: US top ten causes of death (2003): heart disease, cancer, chronic lower respiratory disease, unintentional injury, diabetes, influenza/pneumonia, Alzheimer's, kidney disease, septicemia

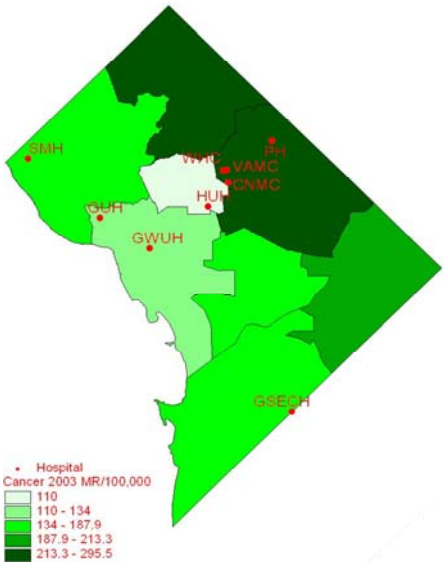
The data show that prevalence of these conditions varies by ward. In addition, the number of hospital discharges is higher in the eastern wards of the city, across conditions and gender. Although rates of chronic diseases vary by ward, the data presented showed no correlation between the location of hospitals and the rate of priority chronic conditions (Figure 3).

Fig. 3 Distribution of Deaths from Chronic Disease by Ward, with Hospital Location

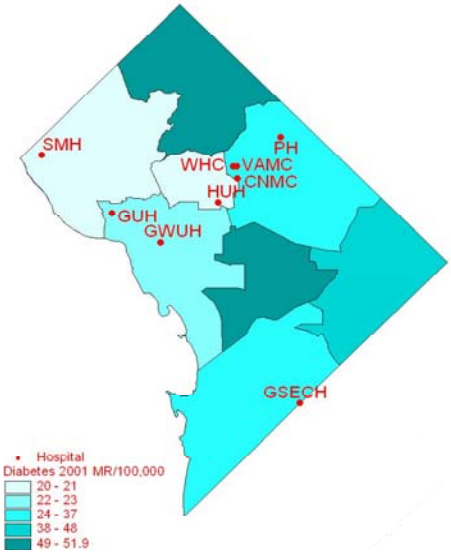
(a) Heart Disease Mortality, 2003




(b) Cancer Mortality, 2003




(c) Diabetes Mortality, 2001

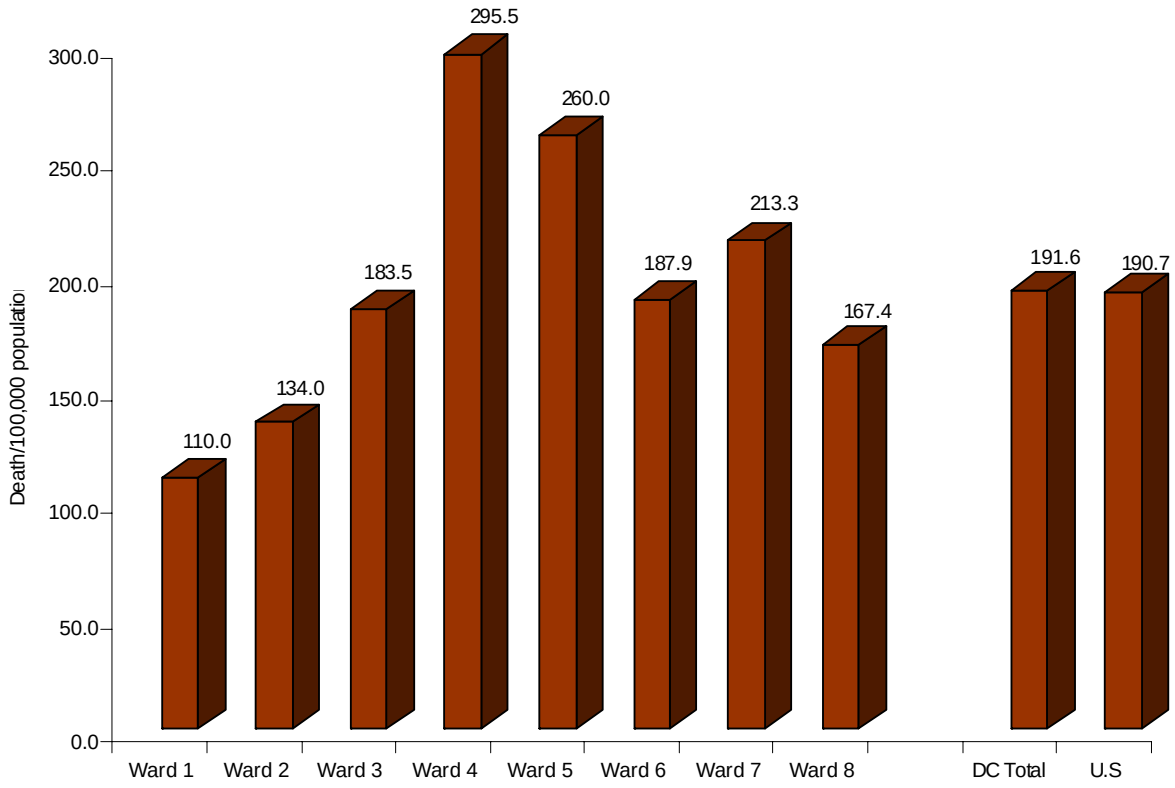




Source: DC DOH statistics and graphics, using GSECH to refer to Greater Southeast Community Hospital

For some measures of health status, such as incidence of cancer, overall District rates are comparable to the national average. These overall rates, however, mask large disparities across the city's wards (Figure 4).

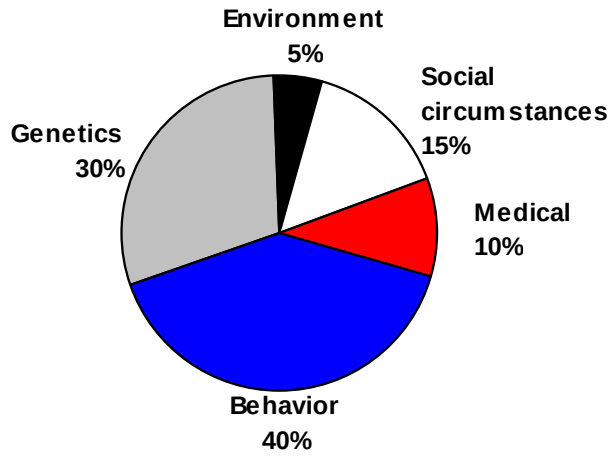
Fig. 4 Death Rates from Cancer by Ward, 2003




Source: Davies-Cole presentation, using data from District of Columbia State Center for Health Statistics
Note: Death Rates are unadjusted for variations in age, other factors

Population health is also determined by factors not related to the health care system. It is often said that health outcomes are 40 percent determined by behavior and only 10 percent by medical care (Figure 5).

Fig. 5 Health Has Many Determinants

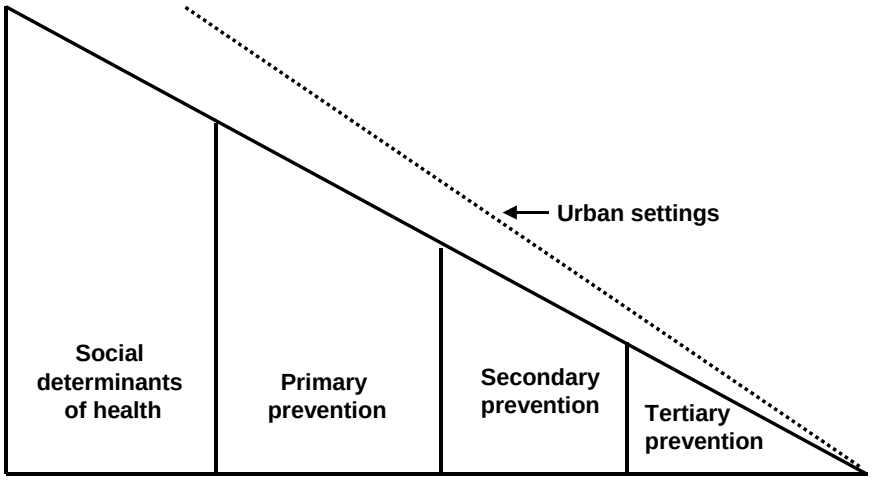



Source: McGinnis et al., Health Affairs 21(2):78-93 (2002).

Different levels of preventive interventions can reduce the incidence and severity of disease by targeting these factors. Primary prevention targets behavioral and environmental risk factors that affect health (e.g., smoking, obesity). Secondary prevention refers to early detection and care of conditions (e.g., screening). Tertiary prevention aims to minimize the risk of recurrence or complications in an existing condition (e.g., management of chronic disease).

Presentations to the Task Force noted that the greatest health benefit can be obtained through primary prevention activities, particularly those that target underlying cause of death, especially in urban areas, where the prevalence of behavioral risk factors is higher (Figure 6).

Fig. 6 Determinants of Population Health



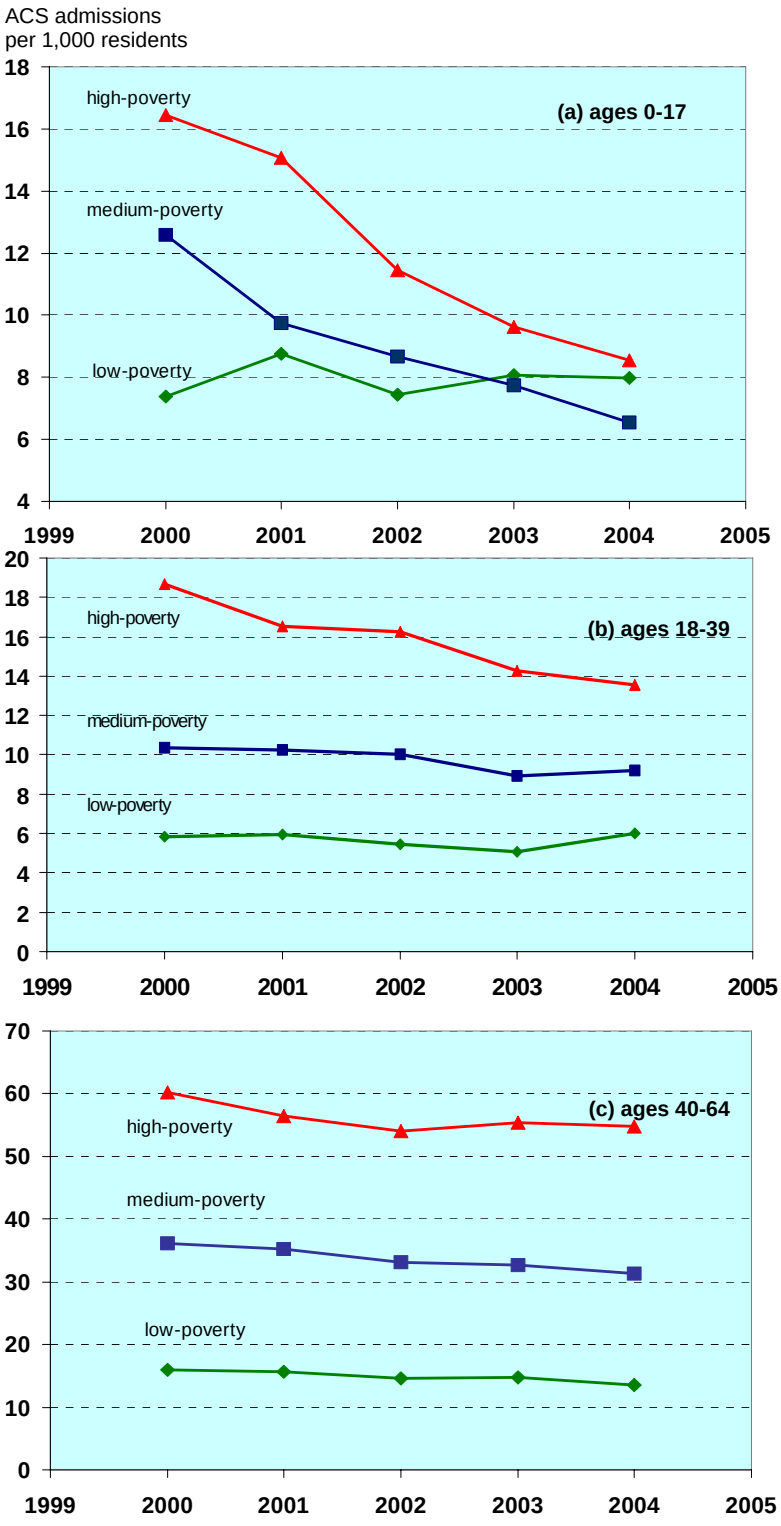

Source: Woolf presentation

Tertiary prevention plays a major role in the management of chronic disease such as hypertension and heart disease. Despite the importance of primary and secondary prevention, only an estimated two to three percent of health resources are spent in these areas of care.

## *Health Care Services: Availability and Gaps*

The Task Force noted that over the past several years, the District has significantly improved access to care for low-income uninsured residents. Improvements are seen as chiefly due to the implementation of the Alliance and Medicaid managed care. Improved outcomes for low-income groups include reduced rates of avoidable hospitalizations for most age groups (Figure 7).

Fig. 7 Trends in Ambulatory-Care-Sensitive Hospital Admission Rates for DC Residents
(by poverty status of Residents' Zip Codes)




Source: DCPCA/Lurie et al., RAND, Oct. 21, 2006
Note: information from DCHA Discharge data, 2000-2004, sorted by poverty status of residents' ZIP Codes

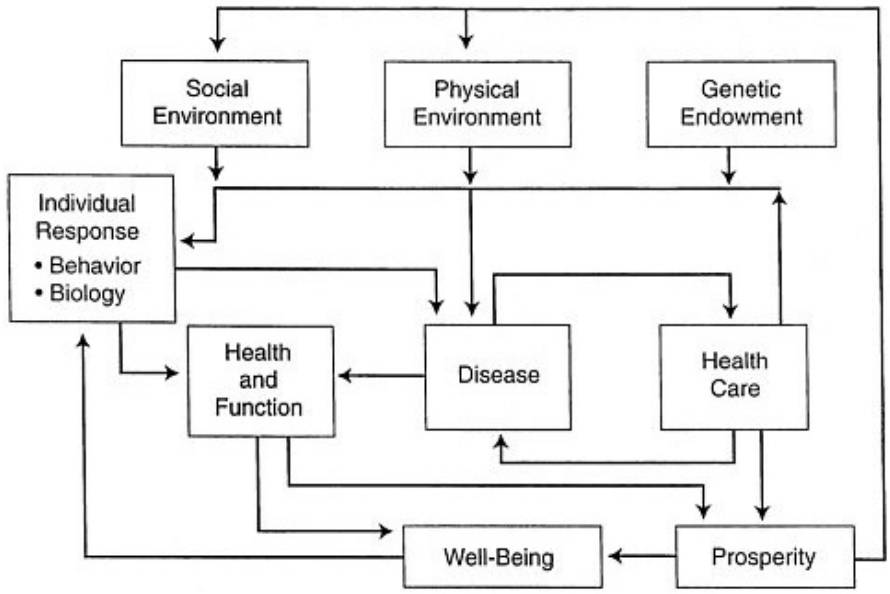
There remain, nonetheless, gaps in care for low-income residents as well as healthcare system issues that inhibit continuity of care for Alliance and Medicaid enrollees. In particular, members noted that access to specialty care is limited by low participation of specialists in these programs, especially the Alliance, where low participation was attributed to low reimbursement rates.

In addition, the health care system was characterized as fragmented. This is evidenced by too little coordination among providers and inconsistent access to follow-up care. For example, although the District achieves very high rates of screening for disease, Task Force members noted that post-diagnosis care to treat identified conditions is often lacking.

The discussion by Task Force members also highlighted factors beyond health services that influence health outcomes, suggesting that increased access to services alone may be insufficient to improve health outcomes. These other factors include patients' coping skills, appropriateness of care, integration of services, quality of care, and efficacy of treatment (Figure 8).

Residents' perceptions of the system's commitment to their health can also affect health-seeking behaviors and thus health outcomes. System effectiveness can be enhanced through partnerships between medical and non-clinical personnel working to integrate healthcare into the daily life of populations most at risk.

Fig. 8 Health Has Many Determinants




Source: Bovbjerg presentation, citing Institute of Medicine (2001)

## *Emergency Services Issues*

## Trauma Care Capacity

Optimal trauma care capacity allows timely access for all residents, while also providing a sufficient number of severe cases at each emergency site in order to maintain the skills of trauma physicians and staff.

National data suggest that one trauma center per million residents allows a trauma center caseload consistent with maintenance of personnel skills. Adequacy of access is measured by the share of residents who can be delivered to a trauma center within 45 to 60 minutes. By these measures, the District's trauma capacity appears sufficient: The number of certified trauma center far exceeds one per million population (Figure 9), and all residents have access to a certified Level 1 trauma center within 45 minutes estimated travel time (Figure 10).

Thus, the greater danger for the three District trauma centers certified by the American College of Surgeons/Committee on Trauma—Howard University Hospital, Washington Hospital Center, and Children's National Medical Center (for pediatric cases only)—lies in whether there is a sufficient number of severe injury cases for these centers to maintain their skill level, given the relatively large number of centers per population.

Members noted that the District's trauma centers draw from the metropolitan area, not just from within the District, that the District's daytime population also includes the uncounted commuter population, and that rates of violent crime within the District might argue for greater capacity. The unequal geographic distribution of certified trauma centers was also noted; the three centers certified by ACS/COT are clustered together just off North Capitol Street. The George Washington University Hospital, located in the West End, also provides high-level trauma care, although it is not ACS/COT-certified. Data were not available to determine the case loads and severity of cases at all of these centers. No consensus could be reached on the issue of trauma center capacity.

Fig. 9 Number of Trauma Centers per Million Population, by State

| | | All Levels | | Level I & II Only | |
|---|---|---|---|---|---|
| | Year of First Designation/ Certification | No. of Centers | Per Million Population | No. of Centers | Per Million Population |
| District of Columbia | 1976 | 3 | 5.24 | 3 | 5.24 |
| Maryland | 1978 | 9 | 1.7 | 7 | 1.32 |
| Pennsylvania | 1986 | 25 | 2.04 | 25 | 2.04 |
| North Carolina | 1982 | 11 | 1.37 | 9 | 1.12 |
| Virginia | 1981 | 12 | 1.7 | 7 | 0.99 |

Source: Branas presentation, citing JAMA article

Fig. 10 Population Percentages with Trauma Center Access, by State

| | Levels I and II Only, % | | Levels I, II, and III, % | |
|---|---|---|---|---|
| | Within 45 min | Within 60 min | Within 45 min | Within 60 min |
| United States, total | 69.2 | 84.1 | 74.2 | 88.7 |
| District of Columbia | 100.0 | 100.0 | 100.0 | 100.0 |
| Maryland | 87.5 | 96.7 | 95.9 | 100.0 |
| Pennsylvania | 88.5 | 99.3 | 89.2 | 99.3 |
| North Carolina | 51.1 | 80.6 | 56.0 | 81.8 |
| Virginia | 71.5 | 90.2 | 75.3 | 92.1 |

Source: Branas presentation, citing JAMA article

Note: travel time is by either ambulance or helicopter and includes access to trauma care resources of neighboring states.

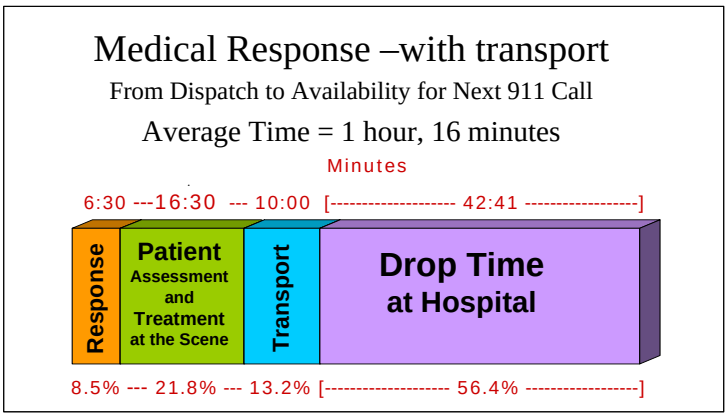
## EMS and Emergency Department Issues

Data presented by the District's Fire and Emergency Medical Services Department suggest several salient issues facing the District's emergency medical system: Average drop times[9] at hospitals are up to three times the national average. There are high rates of closure of emergency departments and diversion of ambulances, as well as problems in transportation of high priority patients (Figures 11 and 12).

The role of "inappropriate" use of the emergency room by patients whose conditions could easily be treated in a primary care setting and the issue of inadequate bed capacity were raised, but no conclusions were reached as to the degree to which emergency room crowding could be attributed to these factors.

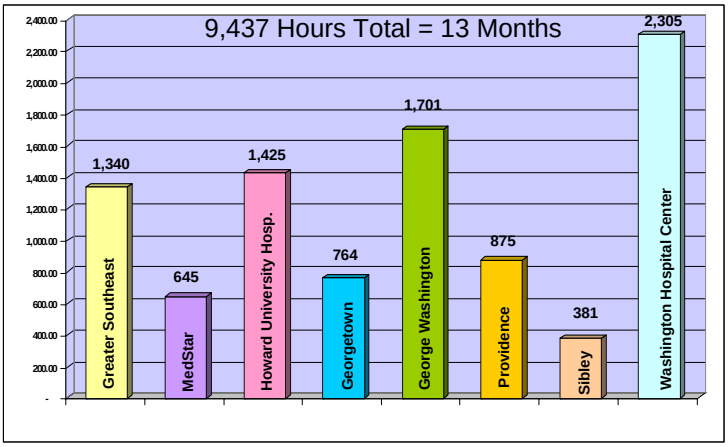
Task Force members compared the F/EMS call for increased emergency room capacity with an earlier presentation that gauged trauma physical capacity as more than adequate. A high number of trauma cases originate east of the river, where there is no Level 1-certified trauma center. It was reported to the Task Force that trauma directors at George Washington University Hospital and Washington Hospital Center indicated that there is no current data showing differences in survival rates for the most severely injured based on location of trip origin. No conclusion could be reached on this issue.

Fig. 11




Source: Wadhwa presentation, FEMS data

Fig. 12 Emergency Rm. Hrs. of Closure & Diversion – CY 2005
Eight Major DC Adult Receiving Facilities




Source: Wadhwa presentation, FEMS data

[9] Drop time is the time between when an ambulance arrives at the hospital and when it is available for the next call.

## Financial Stability of Existing Hospital Capacity

The Task Force received presentations by both Howard University and Greater Southeast Community Hospital, the two hospitals specifically mentioned in the Mayor's charge. In addition, GSCH participated on the Task Force, allowing the effect of various proposals on the financial viability and stability of its facility to be taken into account in all discussions.

Task Force members recognized the historical role that Howard's medical school has played in the education of minority physicians and in service to the underserved in the District. Members also recognized the importance of having adequate facilities for the continuation of Howard's missions of teaching and service.

In their presentation to the Task Force, Howard University officials expressed their belief that the NCMC was the best solution to the health care access problems in eastern Washington but noted their interest in being a part of any solution that the District may put in place.

The Task Force recognized the importance of GSCH as the only acute care hospital east of the Anacostia River, serving Wards 7 and 8. In its presentation, GSCH outlined its vision of a facility that would meet many of the recognized service gaps east of the river, such as trauma care, pediatric and adolescent health services, and ambulatory care. Task Force members recognized the importance of GSCH's location for residents living east of the river, but also noted both its history of financial problems and its ownership by a proprietary entity headquartered outside the District.

## Financing Available for Investment

A presentation to the Task Force from the Office of the Chief Financial Officer explained that the planned securitization of future tobacco-settlement revenues is expected to yield about $212 million, and that the District needs to act soon in order to take advantage of these funds. The precise amount raised will depend upon the final design of the bonds sold as well as market conditions at the time.

The Task Force was advised that they should feel free to suggest any mix of spending they believe would be most beneficial to the District. The funds may be allocated either to purchase "bricks and mortar" or make a grant or grants for public uses.

## *Hospital Payment Issues*

### Disproportionate Share Hospital Funds

The Medicaid DSH program is shaped by federal requirements and spending caps as well as local decisions on how to distribute program allotments. The District's DSH program represents a share of total Medicaid spending that is similar to neighboring state programs. Current allocations support the Alliance, St. Elizabeth's, and nine private hospitals (Figure 13).

Washington Hospital Center has recently been qualified as a DSH hospital and will be added to the FY 2006 distribution. In its allocation of DSH funds across hospitals, the District, unlike most states, bases its allocation on the number of Medicaid inpatient days only, without taking the level of uncompensated care into account.

Recent federal actions have increased the District's Medicaid DSH allotment and have allowed states greater flexibility in how these funds can be spent, making this a time of potential change for the program. In particular, federal waivers now allow states to direct DSH funds to areas other than hospitals. Members considered innovative programs in San Antonio, Texas, and the state of Georgia as examples of non-hospital based DSH programs. Task Force members noted that some decisions regarding the allotment of the new federal funds had already been made.

Fig. 13 Allocation of Medicaid DSH Funds, 2005

| | FY 2005 | | |
|---|---|---|---|
| | **DSH Allocation** | **Federal Share (70%)** | **Local Share (30%)** |
| **50-64 Waiver** | $12,857,143 | $9,000,000 | $3,857,143 |
| **Health Care Safety Net** | $5,636,571 | $3,945,600 | $1,690,971 |
| **Public Hospital** | | | |
| St. Elizabeth's | $831,015 | $581,711 | $249,305* |
| **Private Hospitals** | | | |
| Children's | $11,758,572 | $8,231,000 | $3,527,571 |
| Greater SE | $3,733,934 | $2,613,754 | $1,120,180 |
| HSC | $1,936,408 | $1,355,486 | $580,922 |
| Howard | $12,735,014 | $8,914,510 | $3,820,504 |
| MedLINK | $139,721 | $97,805 | $41,917 |
| Providence | $3,059,370 | $2,141,559 | $917,811 |
| Psychiatric | $426,307 | $298,415 | $127,892 |
| Riverside | $709,945 | $496,692 | $212,984 |
| Subtotal | $34,499,271 | $24,149,490 | $10,349,781 |
| | | | |
| **Total** | **$53,824,000** | **$37,676,800** | **$16,147,200** |

Source: Coughlin presentation

## Diagnosis-Related-Group Payment Weights[10]

In addition to Medicaid DSH payments, some hospitals also receive DSH payments as an add-on to their Medicare rates. The basic Medicare rate is a fixed payment per admission determined, in large part, by the Diagnosis Related Group (DRG) in which the patient is classified. DRGs are defined according to the patient's primary reason for admission, comorbidities, and the presence or absence of certain types of surgical procedures.

Hospitals can receive a higher DRG rate if they serve a large number of low-income Medicare and Medicaid patients. The formula for this add-on can be related to either the share of Medicare patients also enrolled in Medicaid and the share of Medicaid patients overall or, for urban hospitals with more than 100 beds, a high dependence of state and local revenue to support indigent care (other than Medicaid).

According to data from the Centers for Medicare and Medicaid Services (CMS), in April 2006, six District hospitals qualified for a DSH add-on to the basic DRG rate (Figure 14).

These add-ons are part of federal Medicare payments, so the prevailing allocation across hospitals reflects their shares of Medicare patients and is not affected by District policies.

D.C. Medicaid fee-for-service hospital payments are also based on DRGs. However, unlike Medicare rates, the rates D.C. Medicaid pays each hospital reflect not only the conditions and procedures associated with each patient, but also include hospital-specific rates related to operational expenses, capital expenses, as well as medical education. (Adjustments are also made for very high cost cases in the form of "outlier" payments.) Thus, differences in costs across hospitals can affect Medicaid expenditures depending on where Medicaid patients not in managed care are treated.

Fig. 14 Medicare DRG payment weights (2006)

| Hospital | add-on % |
|---|---|
| Howard University Hospital | 48% |
| Greater Southeast Community Hospital | 37% |
| Providence Hospital | 27% |
| George Washington University Hospital | 13% |
| Washington Hospital Center | 13% |
| Georgetown University Hospital | 5% |

Source: staff compilation of CMS data

[10] The Task Force meeting schedule did not allow time for members to discuss DRG payment weights, so the following represents a Task Force staff report on this issue.

## Additional Issues Noted

A number of other important issues were raised. However, time did not permit their consideration in depth.

These issues related to health needs and services, the health-care system, financial matters, and other matters:

*Health needs and services:*

- factors in the social and physical environment that promote healthy behaviors
- models for disease management
- patterns of emergency room use in eastern Washington
- development of an after-hours care alternative
- gaps in mental health and substance abuse services
- co-location of specialty services at existing community clinics

*Health-care system:*

- system fragmentation and connectivity of patient information systems
- electronic health records
- healthcare system conditions that would facilitate the delivery of effective and efficient health services to the currently underserved
- reporting requirements for effective monitoring of health conditions and health system efficiency, including trauma care reporting
- innovative service delivery models in other jurisdictions that encourage efficient and high-quality health care
- efficient communication within the health system and between the health system and potential system users

*Finance:*

- reimbursement rates for specialty care
- role of ongoing insurance coverage
- sustainability of investment in additional capacity

*Other:*

- promotion of effective health-seeking behaviors
- role of personal responsibility in disease prevention and of social responsibility to support healthy choices
- creation of a permanent health commission to consider planning, organization, and best practices.

# Recommended Alternatives

## *Preliminary List of Potential Options*

Members were asked to submit written proposals that were consistent with the Mayor's charge. A preliminary list of options based on the submissions and discussions at Task Force meetings was developed and was unanimously accepted by the Task Force as the starting point for discussion. The list included the following options:

- Enhancement of hospital capacity in Ward 8
- A 50-bed community hospital on Reservation 13
- A healthplex[11]
- Some number of ambulatory care centers
- Initiatives to improve primary care access and outcomes
- Emergency medical system infrastructure improvement initiatives
- Alternative transportation to care options
- Interventions to address social determinants of health and/or to improve health system quality and financial viability
- A modified NCMC proposal

Task Force members agreed that these options represented reasonable alternative ways to spend the available $212 million and could form the basis of final discussion of options to be passed forward to policymakers.

[11] A healthplex includes such services as emergency care, primary and specialty care physician offices, ambulatory surgery, diagnostic imaging, laboratory, and health education. Formal partnership(s) with hospital(s) provides ready access to care for patients needing more intensive treatment.

### Discussion of Options

The Task Force's discussion of these preliminary options presumed that the original NCMC proposal remains an option and that additions as well as deletions from the list were allowed.

Members who had submitted written proposals presented their proposals to the Task Force prior to the discussion.

The discussion of the options touched on the following issues:

- the geographic distribution of facilities
- integration of proposed facilities with other parts of the healthcare system
- impact of new capacity on existing providers
- support for specialty services and options for expanding access
- reimbursement rates
- barriers to care with particular reference to care for chronic disease
- disaster preparedness
- the need for new or relocated inpatient beds
- cost to the District and level of funds leveraged
- sustainability of the investment over the long-term

## Four Final Alternatives

The discussion of the preliminary list of plausible options yielded consensus on four options for continued consideration, each with a range of expenditures on inpatient capacity, ambulatory care capacity, and system improvement.

### Overview

Two options would invest the bulk of the funds in additional or improved capacity at hospitals. These options are:

1) A modified version of the proposed NCMC that adds systems integration and community components to the original proposal.
2) Renovation of Greater Southeast Community Hospital and upgrade of its trauma capability; investment in additional ambulatory care capacity, including an ambulatory care facility on Reservation 13; and investment of remaining funds in healthcare system infrastructure to promote disease prevention and system efficiency and quality.

The other two options would invest the bulk of the funds in ambulatory care and system improvement. These options are:

3) A healthplex-type facility at Reservation 13 and additional ambulatory care facilities in eastern Washington; less extensive renovation at GSCH including added ambulatory care capacity; and investment of remaining funds in other healthcare system infrastructure to promote disease prevention and system efficiency and quality.
4) No investment in hospital capacity; one or two new ambulatory care facilities; possible expansion or enhancement of existing ambulatory care facilities; and investment of remaining funds in other healthcare system infrastructure to promote disease prevention and system efficiency and quality.

The detailed component parts of these option sets are described below.

### General principles underlying all alternatives

The Task Force discussion did not reach any conclusions about ownership of any of the proposed facilities or other investments (other than at the GSCH site). Therefore, the listing of any option is separate from any decision about the facility's ownership or ongoing operation. The Task Force recognizes Howard University, GSCH, and any other current or new health care provider could be considered as partners in any facility investment undertaken by the District.

The short timeframe in which the Task Force operated precluded detailed consideration of the costs of each investment. The proposed investments are presented as reasonable constructs for addressing identified needs, not yet as fully fledged proposals. The cost presented for each investment represents the best estimate of Task Force members and staff and may be a range rather than a single amount. The appropriate size of each investment remains to be determined—by assessments of need and after due diligence review of fiscal projections.

The estimated cost of each investment does not include site acquisition costs, if any. Total costs to the District for any facility investment would depend on cost-sharing arrangements with the owner of the facility.

Investment in facilities and, to a lesser extent, other infrastructure will require ongoing funding for sustainability. Identification of ongoing funding for sustainability will be part of the due diligence investigation of each option.

Final discussion of options and votes on recommendations used the following options matrix accepted by the Task Force (Figure 15).

Fig. 15 Health Care Alternatives for Reservation 13 and Eastern Washington

| Proposals | Components of Proposals: Hospital investments | Investments in improved access to ambulatory care | Other infrastructure and investments in prevention, system quality and efficiency |
|---|---|---|---|
| ***Proposal already under consideration*** | | | |
| NCMC<br>total = $212 million | includes:<br>- full-service medical center<br>- 24/7 ED with level I trauma<br>up to $212m[1] | proposal includes:<br>- physician office complex on Res. 13<br>- outpatient surgery<br>$0m[2] | - medical research facility on Res. 13[2]<br>- state-of-the-art throughout, including IT<br>- links with community clinics<br>$0m[2] |
| ***Alternative proposals from Task Force*** | | | |
| 1. NCMC, with additions to help integrate into community<br>total = $212 million | same as original plus, e.g.:<br>- behavioral health beds<br>up to $212m[1] | same as original<br>$0m[2] | same as original, plus, e.g.:<br>- IT links w/ community providers & govt services<br>- EMS training and disaster preparedness<br>- community advisory board<br>$0m[2] |
| 2. GSCH major renovation and expansion[3] | a. full renovation, including:<br>- expansion of staffed beds<br>- upgrade to trauma level II<br>up to $188m[4] | proposal includes:<br>- ambulatory care walk-in clinic<br>$0m | modest investment in systems improvements[5], e.g.:<br>- ED/EMS study<br>$14m (or balance of $212m) |
| | b. lesser renovation, with focus on areas of highest assessed need<br>total = $212 million<br>up to $120m[4] | - HealthPlex[6] at Reservation 13<br>up to $50m | signif. investment in systems improvements[5], e.g.:<br>- above plus grants for, e.g., electronic health<br>$42m (or balance of $212m) |
| 3. HealthPlex[6] at Res. 13 (plus lesser renovation for GSCH & new ambulatory care center) | partial renovation of existing GSCH facility, new ambulatory care clinic, some upgrade of trauma capabilities | a. HealthPlex[6] at Reservation 13<br>- renovation of and co-location of specialty care in existing CHCs[6]<br>up to $80m | significant investment in systems improvements[5]<br>- above plus, e.g., non-EMS medical transit system<br>$52m (or balance of $212m) |
| | | b. 2 ambulatory care clinics (Res. 13 & Ward 7)<br>- renovation and/or expansion of existing clinics<br>up to $132m | minimal investment in systems improvements[5]<br>$0m (or balance of $212m) |
| | total = $212 million<br>up to $80m | | |
| 4. Ambulatory care and other components<br>total = $212 million | - no hospital beds<br>$0m | - one or two ambulatory care centers sited and sized to meet identified needs<br>- consideration of expanding and enhancing existing primary sites rather than building new[7]<br>up to $80m | large investment in prevention, improved systems operations[5], e.g.:<br>- electronic health records<br>- smoking cessation<br>$132m (or balance of $212m) |

Notes: see next page

## Notes for options matrix

*General notes:*

Total costs to the District for any facility investment depend upon the cost-sharing arrangements with owner of facility.

The listing of any facility or any other investment as an option is separate from any decision about the facility's ownership or ongoing operations. Howard University, GSCH, and any other current or new health care provider could be considered as partners in any investment undertaken by the District.

Dollar amounts are estimates by proponents or staff. The appropriate size of any component investment is to be determined by assessed need and after due diligence review of its fiscal projections; residual funds are to be reallocated across the remaining components.

Investments in facilities all require ongoing funding for sustainability. Funding sources for consideration include DSH allocations, DOH budget, and other funds.

Some public health and/or EMS functions could also be shifted to Reservation 13 using operating funds only.

*Specific notes:*

1. $212 million is the agreed ceiling on direct District cost for half of the medical center portion of NCMC (including contingency funds)
2. Howard has agreed to pay full costs of associated physician office complex, research facility
3. District investment in GSCH assumes not-for-profit status for GSCH.
4. District cost does not include site acquisition costs, if any.
5. Other potential components might include, but are not limited to: study of emergency department utilization, trauma transport, and EMS issues ($1-2m); -smoking cessation programs (up to $14m); prevention grants ($10-$30); diabetes and asthma management grants ($TBD); -healthcare system quality and efficiency initiatives ($TBD); new non-EMS transit system ($3-$5m); electronic health records ($20-40m).
6. A Healthplex includes such services as emergency care, primary and specialty care physician offices, ambulatory surgery, diagnostic imaging, laboratory, and health education. Formal partnership(s) with hospital(s) provides ready access to care for patients needing more intensive treatment.
7. Other investments in ambulatory care might include, but are not limited to: freestanding ER ($8m); feeder or satellite clinics linked to partner hospitals ($5-16m each); embedded clinics (e.g., Minute Clinics) in high foot-traffic areas ($1-3m each); renovation of existing primary care capacity (up to $40m); development of specialty capacity (e.g., "circuit riding") at existing clinics ($50-100,000 each).

(Some content of these notes receives further explication in text.)

The options matrix accepted by the Task Force had one column for each type of investment considered—hospital facilities, ambulatory care, and other infrastructure, quality, efficiency, and prevention initiatives. Members supporting one or more components described their view of what investments should be made in each category. The three columns are described next.

### Hospital investments

The Task Force considered investments in inpatient capacity, which could include relocation of already licensed beds or renovation of existing inpatient capacity in eastern Washington. The Task Force envisioned investments that could include construction, renovation, equipment, and training necessary to tailor the investment to community needs. Any investment in GSCH assumes not-for-profit status for the facility and a change in governance and ownership.

The enhanced NCMC proposal adds components, at no additional cost to the District, that reflect the discussion of needs in the Task Force's deliberations. These include, for example, a community advisory board to assure that the needs of the community are taken into account in operations, electronic linkages between the facility and providers in the community and relevant government programs, and addition of EMS training to Howard University's Allied Health program.

Investments at GSCH range from expansion and full renovation of the facility and upgrading of trauma capability to Level 2, to smaller investments targeted at areas of identified need, such as the addition of ambulatory care capacity, a new pediatric and adolescent health services, and partial renovation of priority services.

### Investments in improved access to ambulatory care

Ambulatory care investments were intended to provide access to the full range of primary and outpatient specialty care services. Proposals included outpatient clinics at existing hospitals, a healthplex-type facility, community clinics, urgent care centers, school-based clinics, and storefront clinics at locations in eastern Washington.

There was considerable Task Force interest in providing high-quality ambulatory care services at Reservation 13. The Healthplex concept, as established by Inova Hospital, was offered as an example of a desirable facility. The Inova Healthplex includes such services as 24/7 emergency care, primary and specialty care physician offices, ambulatory surgery, diagnostic imaging, laboratory services, and health education. Formal partnership with a hospital or hospitals as well as established transportation service would provide ready access to care for the minority of patients needing more intensive treatment than could be offered on-site.

The Task Force envisioned the possibility of smaller facilities located in geographically dispersed areas in eastern Washington to serve residents in their communities. These facilities could be based in areas of high need with currently low access. The Task Force saw renovation of existing community-based ambulatory care facilities with possible co-location of specialty services as another option. School-based clinics and storefront clinics could meet some community needs by bringing services to areas with already high foot-traffic. The Task Force recommended that facilities be sited, sized, and equipped based on the needs of the community in which they are located.

Other infrastructure and investments in prevention, system quality and efficiency

This category comprised a number of components designed to improve District health status or health services apart from adding new capacity in inpatient or ambulatory settings. Many ideas respond to the indications that primary prevention can have a very large impact on health outcomes (Figure 6 above). A minority of Task Force members thought that substantial funds should be invested in such non-facility initiatives to reduce the incidence of, in particular, chronic disease and cancer, and to improve health outcomes.

There was substantial interest among Task Force members in the following specific initiatives:

- a study of emergency-department utilization, trauma transport, and other EMS issues
- a new, non-EMS health-related transportation system
- electronic health records
- smoking cessation initiatives

The proposed study of emergency department utilization, trauma transport, and other EMS issues reflected the Task Force's inability to come to consensus on trauma and EMS issues. Members called for more information in order to improve understanding of the nature and extent of problems in the continuum of emergency services —demand for care, EMS transport, drop-times, patient waiting times, and timeliness of transfer to inpatient beds. Although this study had general support, many Task Force members wanted to fund it apart from the specific $212 million at stake in Task Force deliberations. Members were also cognizant that another task force is addressing emergency services.

Other system infrastructure components suggested by Task Force members include, but are not limited to the following:

- chronic-disease management demonstrations, notably for diabetes and asthma
- programs for the management of emergency room "frequent flyers"
- other healthcare system quality and efficiency initiatives

Other than for the EMS study, the expectation was for demonstration projects based on successful initiatives in other jurisdictions rather than research alone. The goal is to demonstrate success of an intervention and thus encourage broader local adoption. One idea noted was to create a new public-private institute that could make grants of appropriate sizes to a number of worthy projects. The institute would carefully assess each proposal's logic model and feasibility in ways not possible in the short Task Force process.

Most of the components are scalable, that is, they could operate successfully with different levels of support. For example, grants for physicians and clinics to help fund adoption of electronic health records could be larger or smaller depending upon the level of support envisioned for the costs of purchase, training programs, staff time spent in training, and the contribution by the physician or clinic. The grants could also be targeted, for example, to providers located in low-income areas or whose caseload has at least a threshold percentage of uninsured, Alliance, or Medicaid patients.

## *Single Preferred Alternatives of Majority and Minority*

A straw poll of Task Force members was taken to tabulate preferences about each of the four plausible options. There were five votes for option #1, one vote for option #2, seven votes for option #3, and two votes for option #4. In this vote, the Task Force did not distinguish between option variants 2a and 2b or 3a and 3b, seen in the table.

Based on these expressed preferences, additional discussion focused on options 1 and 3 as those of most interest to the members. Option #1 had been described in detail in documents provided by the major proponents of that option, so that proposal details were well-known.

The discussion of option #3 added specificity to its ambulatory care components. Following extensive discussion of desirable components of the proposed facilities, the members agreed on the following general principles that would guide the planning of these facilities:

- Facilities should be sized and sited based on needs data.
- Facilities should be located in the eastern part of the city, with particular consideration given to facilities at Reservation 13 and east of the Anacostia river.
- Services at each facility should be customized to neighborhood needs.

At the end of all deliberations, a roll call vote was taken to gauge members' preference for the final two options. There were ten votes for option #3 and five votes for option #1. As before, the Task Force did not distinguish between options 3a and 3b.

The Chair did not vote, and two Task Force members were absent. A tally of the roll-call vote by member is provided in the appendix.

# Next Steps

The compressed timeframe for Task Force deliberations necessitated prioritization of tasks. It was not feasible to develop detailed, final specifications of the alternatives pursuant to the Mayor's charge.

The four plausible options described above each indicate the relative levels of investment suggested for hospital capacity, ambulatory care capacity, and system improvements and prevention—the types of component in each option. However, the components have intentionally been described in general terms, sometimes as a range of investment, so as to leave flexibility for subsequent decision makers. Those further decisions are expected to add detail and decide on the precise scope of each investment undertaken, whatever components are finally decided upon.

The Task Force considered the nature of such decision making, without having the time or mandate to make final decisions. Task Force members agreed on a set of principles against which to measure the various alternatives as they become more fully specified (Figure 16).

Fig. 16. Metric for Assessing Options

- **Costs**
  - one-time, up-front costs
  - ongoing, operating costs
  - sustainability
- **Benefits**
  - improved systems efficiency
  - better access to health services
  - improved health status
- **Possible implementation barriers**

Source: Task Force poster

It was agreed that both one-time, up-front costs and ongoing operating costs should be taken into account. The total of one-time costs was understood to be set by the funds available under the tobacco settlement funds securitization agreement. Taking ongoing costs into account was seen as necessary to assure sustainability of any investment.

The benefits are to be measured as contributions to system efficiency in order to ensure that the District receives the full value of its investment, as well as contributions to improved access to personal health services, particularly in eastern Washington, and improved health outcomes as seen in public health statistics.

Finally, the Task Force agreed that it is appropriate to take account of possible barriers to implementation that might arise with any of the alternatives. Such barriers might include political considerations or community perceptions.

The chairman and the entire Task Force supported using all of the funds available from tobacco-settlement securitization for health care investments. They have suggested several plausible options as well as the most preferred set of investments to help improve the health of District residents and enhance access to care across eastern Washington. The Task Force appreciates having had the opportunity to help contribute to such improvement.

# Appendices

**Materials Included Here**

1. Mayor's Order dated April 19, 2006
2. Task Force Staff
3. Roll Call Vote
4. List of Materials Distributed to Task Force Members

**Other Task Force Materials Available Only on the Web:**

Task Force meeting agendas, May - July 2006
Meeting minutes, May - July 2006

This report and appendices will be posted for a limited time on The Urban Institute website at www.urban.org/healthcareforce/ as of noon, August 2, 2006.

All materials will be posted on the Department of Health website:
www.dchealth.dc.gov

## *Appendix 1. Mayor's Order dated April 19, 2006*

Establishment and Appointments – Mayor's Health Care Task Force

Office of the Mayor

By virtue of the authority vested in me as Mayor of the District of Columbia by section 422(11) of the District of Columbia Home Rule Act, as amended, Pub. L. No. 93-198, 87 Stat. 790, D.C. Official §1-204.22(11)(2001), it is hereby
**ORDERED** that:

**I. ESTABLISHMENT**

There is hereby established in the Executive Branch of the Government of the District of Columbia, the Mayor's Health Care Task Force (hereinafter referred to as the "Task Force").

**II. PURPOSE**

The Task Force shall advise the Mayor, the Council of the District of Columbia, and the Director, Department of Health, on alternatives for improvements in the health care presence in the eastern section of the District.

**III. FUNCTIONS**

The functions of the Task Force shall include:

a. Reviewing the type of health care facility on Reservation 13 that would best meet the needs of the community considering all types of health care approaches, including primary, specialty and emergency care services, and a full-service hospital as recommended in the National Capital Medical Center (NCMC) proposal;

b. Examine alternative approaches to a full-service hospital model, including an ambulatory care center, an urgent care center or a healthplex;

c. Identifying the District's most pressing health care issues;

d. Developing recommendations to promote the financial stability of all existing hospitals in the District and to improve emergency room infrastructure;

e. Recommending ways to shore up the financial viability and quality of services at Greater Southeast Community Hospital in tandem with ensuring the continued stability of Howard University Hospital; and

f. Examining the use and allocation of disproportionate share dollars and Diagnostic-Related Group payment weights for hospitals in the District in an effort to promote equity and the most appropriate use of these funds.

**IV. COMPOSITION**

a. The Task Force shall be comprised of not more than 25 voting members appointed by the Mayor.

b. The members appointed to the Task Force may include representation from the following:

    1. Hospitals and primary care facilities;

    2. Associations, societies, think tanks, policy groups, and other organizations which have as their primary focus and mission the provision of, or advocacy

for medical, emergency care, primary care, care for persons with disabilities, specialty care or preventative health care;

3. Health maintenance organizations;
4. Health insurance companies or organizations;
5. Colleges or universities;
6. Organizations that develop or market pharmaceuticals;
7. Organized labor;
8. Consumers of health care;
9. Public officials; and the
10. General public.

c. Members of the Task Force shall be residents of the District, or shall represent a business, social service organization, educational institution, or other entity located in the District.

## V. TERMS

a. The members of the Task Force shall serve, at the pleasure of the Mayor, until the submission of a final report, but no later than August 31, 2006. In the event of a vacancy, a new member may be appointed to fill an unexpired term and shall serve for the remainder of that term, or until August 31, 2006.

b. The Chairperson may excuse a member from a meeting for an emergency reason.

c. The Mayor may remove any member who fails to attend three (3) unexcused, consecutive meetings of the Task Force.

d. A member may be removed by the Mayor from the Task Force for personal misconduct, neglect of duty, conflict of interest violations, incompetence, or official misconduct. Prior to removal, the member shall be given a copy of any charges and an opportunity to respond within 10 business days following receipt of the charges. Upon a review of the charges and the response, the Director of the Office of Boards and Commissions, Executive Office of the Mayor, shall refer the matter to the Mayor with a recommendation for a final decision or disposition. A member shall be suspended by the Director of the Office of Boards and Commissions, Executive Office of the Mayor, on behalf of the Mayor.

## VI. COMPENSATION

All members of the Task Force shall serve without compensation, except that a member of the Task Force may be reimbursed for reasonable expenses incurred in the authorized executive of official Task Force duties, if approved in advance by the Chairperson of the Task Force, or designee, and subject to the availability of appropriations.

## VII. ORGANIZATIONS

a. The Mayor shall appoint a Chairperson from among the appointed members of the Task Force. The Chairperson shall serve in that capacity at the pleasure of the Mayor.

b. The Task Force may establish subcommittees as needed. Subcommittees may include persons who are not members of the full Task Force, provided that each subcommittee is chaired by a Task Force member and includes a majority of Task Force members.

c. Members appointed by the Mayor may designate in writing alternate members to attend meetings on their behalf, but the alternate members shall not be permitted to vote on matters coming before the Task Force.

d. The Task Force may establish its own bylaws and rules of procedure, subject to the approval of the Mayor or his designee.

e. There shall be no voting by proxy by members of the Task Force.

**VIII. ADMINISTRATION**

The Department of Health shall provide administrative, clerical and technical support to the Task Force.

**IX. SUNSET**

The Task Force shall sunset on August 31, 2006.

**X. APPOINTMENTS**

a. The following individuals are appointed as members to the Task Force to serve for a term not to exceed August 31, 2006:[12]

| | |
|---|---|
| **A. CORNELIUS BAKER** | **MICHAEL BARCH** |
| **SHARON BASKERVILLE** | **COLENE DANIEL** |
| **VANESSA DIXON** | **M. JOY DRASS** |
| **VICTOR FREEMAN** | **VINCENT KEANE** |
| **ROBERT MALSON** | **KWAME ROBERTS** |
| **MICHAEL ROGERS** | **SARA ROSENBAUM** |
| **ERIC ROSENTHAL** | **EDWARD SHANBACKER** |
| **BAILUS WALKER** | **HENRY J. WERRONEN** |
| **RICHARD WOLF** | |

b. **GREGG A. PANE, M.D.** is appointed as a member of the Task Force representing the District government for so long as he remains in his position with the District, and shall serve in that capacity at the pleasure of the Mayor.

c. **GREGG A. PANE, M.D.** is appointed as Chairperson of the Task Force and shall serve in that capacity at the pleasure of the Mayor.

**XI. EFFECTIVE DATE:** This Order shall be effective *nunc pro tunc* to April 19, 2006.

_____

**ANTHONY A. WILLIAMS**
**MAYOR**

**ATTEST:_____**
**PATRICIA ELWOOD**
**INTERIM SECRETARY OF THE DISTRICT OF COLUMBIA**

[12] N.B. Henry J. Werronen was not able to participate on the Task Force. Separately, Raymond J. Brown was later added to the Task Force.

### *Appendix 2. Task Force Staff*

*D.C. Department of Health*

Leila Abrar
Jacqulyn Childs
Patrice M. Dickerson
Sanja Partalo
Feseha Woldu

*The Urban Institute*

Randall R. Bovbjerg
Barbara A. Ormond
Althea Swett

*Economic and Social Research Institute*

Jack Meyer

### *Appendix 3. Roll-Call Vote*

Mayor's Healthcare Task Force
Roll-Call Vote on Alternative Options
11 July 2006

| member | for option 1 or 3? |
|---|---|
| Gregg A. Pane, Chair | not voting |
| 1. Cornelius Baker | not present |
| 2. Michael Barch | 1 |
| 3. Sharon Baskerville | 3 |
| 4. Raymond Brown | 1 |
| 5. Colene Daniel | 3 |
| 6. Vanessa Dixon | 1 |
| 7. M. Joy Drass | 3 |
| 8. Victor Freeman | 1 |
| 9. Vincent Keane | 3 |
| 10. Robert Malson | 3 |
| 11. Kwame Roberts | 1 |
| 12. Michael Rogers | 3 |
| 13. Sara Rosenbaum | 3 |
| 14. Eric Rosenthal | 3 |
| 15. Edward Shanbacker | 3 |
| 16. Bailus Walker | not present |
| 17. Richard Wolf | 3 |

## *Appendix 4. Documents Distributed to Task Force*

(distribution occurred either by email or in hard copy)

### Documents Distributed to Task Force before Start of Meetings

#### Meeting 1: May 2, 2006

*Improving Health Insurance Coverage in the District of Columbia*, Report of the Health Care Coverage Advisory Panel to the D.C. Department of Health under Its State Planning Grant. May 1, 2006.
*Presents findings of the Health Care Coverage Advisory Panel to the D.C. Department of Health under its State Planning Grant. Discusses eight recommendations to decrease the rate of uninsurance in D.C.*

*Data Book*, D.C. Department of Health, Bureau of Epidemiology and Health Risk Assessment and Office of Policy, Planning and Research. September, 2005.
*Provides a descriptive analysis of District of Columbia hospital discharge data for 1997-2002, as well as a descriptive analysis of the leading causes of mortality in the District for 1999 and 2000.*

*Where we are. Where we need to go. The Primary Care Safety Net in the District of Columbia, 2005 Update*. District of Columbia Primary Care Association, 2005.
*Contains summaries of the District's safety net including total number of safety net clinics, types of providers, locations of clinics (including ward information), services available, number of patients, patient demographics, financing of programs, health of community, and policy recommendations.*

#### Meeting 2: May 9, 2006

Correspondence, Office of the Senior Vice President for Health Sciences, Howard University Hospital Ambulatory Care Center to Dr. Gregg A. Pane, MD, Director, Department of Health, May 2, 2006.
*Letter declining to serve on Task Force, with rationale.*

*Framework for a Healthier Greater New Orleans*, report of the Greater New Orleans Health Planning Group, November 10, 2005. (distributed May 5, 2006)
*Report of Greater New Orleans Health Planning group presenting their recommendations for improving the health infrastructure to improve the health of the region's residents.*

*Bring Back New Orleans Health and Social Services Committee*, report and recommendations to the Bring Back New Orleans Commission, January 18, 2006. (distributed May 5, 2006)
*Report of the Social Services Committee to the Bring New Orleans Back Commission convened to discuss and strategize around infrastructural issues in the city post-Katrina.*

*Mayor Appoints Emergency Panel on Healthcare in D.C.*, Government of the District of Columbia, Executive Office of the Mayor, Press Release, Wednesday, April 19, 2006.
*News release announcing the appointment of the Mayor's Health Care Task Force.*

*National Capital Medical Center,* The Mayor's Charge.
*Full copy appears as Appendix 1, above*

*Memorandum – National Capital Medical Care,* To The Honorable Anthony A. Williams, Mayor, District of Columbia Government, From Natwar M. Gandhi, Chief Financial Officer, May 5, 2006 (includes Appendix A, Analysis of Capital Costs, Appendix B, Risk Analysis of Operational Costs).
*An analysis of the potential capital costs and operational risks of a full service hospital in the District of Columbia.*

#### Meeting 3: May 16, 2006

National Capital Medical Center, *The* Mayor's *Talking Points*
*Talking points of the District's Mayor announcing the appointment of the Mayor's Health Care Task Force and describing the panel's mission.*

Branas, Charles C., et al. "Access to Trauma Centers in the United States," *Journal of the American Medical Association*. 2005; 293: 2626-2633. http://jama.ama-assn.org/cgi/reprint/293/21/2626

*A study estimating the proportion of U.S. residents having access to trauma centers within forty-five or sixty minutes.*

MacKenzie, Ellen J., et al. "National Inventory of Hospital Trauma Centers," *Journal of the American Medical Association*. 2003; 289: 1515-1522. http://jama.ama-assn.org/cgi/reprint/289/12/1566
*A study exploring the characteristics, number, and configuration of trauma center hospitals to determine gaps in coverage.*

MacKenzie, Ellen J., et al. "A National Evaluation of the Effect of Trauma-Center Care on Mortality," *New England Journal of Medicine*. 2006; 354: 366-378 [abstract only].
http://www.uwnews.org/relatedcontent/2006/January/rc_parentID22161_thisID22162.pdf
*An investigation of the differences in mortality between level one trauma centers and hospitals without a trauma center to assess the effect of trauma-center care on the risk of death.*

Trunkey, Donald D. "Trauma Centers and Trauma Systems," *Journal of the American Medical Association*. 2003; 289: 1566-1567. http://jama.ama-assn.org/cgi/reprint/289/12/1566
*A brief overview and comment on the findings of MacKenzie et al. in their 2003 article "National Inventory of Hospital Trauma Centers" cited above.*

Susan Levine, "Panel Offers Advice On Health Coverage: Report Identifies the City's Vulnerable," *Washington Post*, Thursday, May 11, 2006, page DZ03.
*An article providing a brief overview of the findings and recommendations of the Health Care Coverage Advisory Panel to the Department of Health under its State Planning Grant.*

### Meeting 4: May 23, 2006

Carr, Brendan G., Joel M. Caplan, John P. Pryor, and Charles C. Branas. "A Meta-Analysis of Pre-Hospital Care Times for Trauma," *Pre-Hospital Emergency Care*, Vol. 10, No. 2: 198-206, 2006.
*A study seeking to determine national averages for times to definitive care (pre-hospital times) based upon a systematic review of relevant published literature.*

Mechanic, David. "Policy Challenges In Addressing Racial Disparities and Improving Population Health: Some Thoughts on Effecting Change within the Current Political and Economic Realities," *Health Affairs*, Vol. 24, No. 2: 335-338, March/April 2005.
*Discusses the promotion of the health and welfare of disadvantaged citizens within the current economic and political context.*

Williams, David R., and Pamela Braboy Jackson. "Social Sources of Racial Disparities in Health," *Health Affairs*, Vol. 24, No. 2: 325-334, March/April 2005.
*A paper outlining factors in the social environment that may initiate and sustain racial disparities in health.*

*Priorities for America's Health: Capitalizing on Life-Saving, Cost-Effective Preventive Services*, A Public Policymaker's Guide by Partnership for Prevention.
*Presents the Partnership for Prevention rankings of the health impact and cost effectiveness of twenty-five preventive health services recommended by the U.S. Preventive Services Task Force and the Advisory Committee on Immunization Practices.*

### Meeting 5: June 6, 2006

David Mechanic, "Policy Challenges In Addressing Racial Disparities And Improving Population Health," *Health Affairs*, March/April 2005.
*Discusses the promotion of the health and welfare of disadvantaged citizens within the current economic and political context.*

David R. Williams and Pamela Braboy Jackson, "Social Sources Of Racial Disparities In Health," *Health Affairs*, March/April 2005.
*A paper outlining factors in the social environment that may initiate and sustain racial disparities in health.*

Carr, Brendan G., Joel M. Caplan, John P. Pryor, and Charles C. Branas. "A Meta-Analysis of Pre-Hospital Care Times for Trauma," *Pre-Hospital Emergency Care*, Vol. 10, No. 2: 198-206, 2006.
*A study seeking to determine national averages for times to definitive care (pre-hospital times) based upon a systematic review of relevant published literature.*

Whelan, David L., and Robert W. Simmons, Stroudwater Associates, "District of Columbia Public Health services, Reservation13/HillEast Site, Strategic Facilities Location Discussions, Final Recommendations Report," September 2004.

Stroudwater Associates, "50-Bed Safety Net Hospital for the District of Columbia; Overview of Estimated Project and Operating Costs," March 2005.
*Brief overview of the estimated initial project costs and annual operating costs of a fifty-bed safety net hospital.*

District of Columbia and Howard University, "National Capital Medical Center," presentation to the Senate Appropriations and Authorizations Committee, March 2006.
*Overview of the National Capital Medical Center proposal including the history of the proposal, the proposed location, the populations to be served, projected costs, and next steps.*

Lisa Mustone Alexander, Director, D.C. Area Health Education Center, "Models For Discussion: Small Urban Hospitals," (no date).
*Offers models of small hospitals to explore how the needs of medically vulnerable residents of D.C. can be best met in relation to hospital and specialty care.*

Office of the Mayor, "Establishment and Appointments – Mayor's Health Care Task Force," effective April 19, 2006.
*A statement of the establishment, purpose, functions, composition, and terms of the Mayor's Health Care Task Force. The document also lists the individuals appointed to the Task Force.*

### Meeting 6: June 13, 2006

Committee Draft of Facility/System Guidepost Options for Discussion, Review, and Development
*Summary of facility and system options discussed by the Task Force to facilitate the fulfillment of the Mayor's Charge.*

Sheila Leatherman, Donald Berwick, Debra Iles, Lawrence S. Lewin, Frank Davidoff, Thomas Nolan, and Maureen Bisognano, "The Business Case for Quality: Case Studies and an Analysis," *Health Affairs*, Vol. 22, No. 2: 17-30, March/April 2003.
*Presents case studies of several initiatives in health care delivery and purchasing organizations to determine whether improved quality reduces margins or provides a return on investment, and what entity realizes a financial benefit from a specific quality initiative.*

Gusmano, Michael K., Victor G. Rodwin, and Daniel Weisz, "A New Way to Compare Health Systems: Avoidable Hospital Conditions in Manhattan and Paris," *Health Affairs*, Vol. 25, No. 2: 510-520, March/April 2006.
*An analysis of avoidable hospital conditions in Manhattan and Paris to assess comparative health system performance.*

*Health Disparities Collaboratives: Improving Diabetes Care in 3,400 Health Center Sites*, with a summary of the Health Disparities Collaborative: Unity Health Care initiative, compiled by Task Force staff. Distributed June 13, 2006.
*Presents a brief outline of the Health Disparities Collaborative, formed by the Institute for Healthcare Improvement and US Department of Health and Human Services. Offers a brief summary of the Unity collaborative program focusing on diabetes management.*

*Successful DOH Chronic Disease Management Program*, Family Treatment Court Residential Substance Abuse Treatment for Women, compiled by Task Force staff. Distributed June 13, 2006.
*Provides a brief summary of the Family Treatment Court Residential Substance Abuse Treatment for Women, as well as budget amount and cost benefit, program outcomes, and performance measures used.*

*Strategies for Change*, Report of the District of Columbia Health Care System Development Commission, December 2000, Excerpt: pp. 7-13.
*Excerpt providing an overview of the recommendations of the Health Care System Development Commission to the Government of the District of Columbia.*

*Systems Improvements Initiatives*, examples of Institute for Healthcare Improvement compiled by Task Force staff. Distributed June 13, 2006.

*Gives a brief summary of health care systems improvement initiatives in Maine, Connecticut, Massachusetts, and Detroit.*

### Meeting 7: June 20, 2006

Lisa Mustone Alexander, Director, D.C. Area Health Education Center, "Models For Discussion: Small Urban Hospitals," (no date).
*Offers models of small hospitals to explore how the needs of medically vulnerable residents of D.C. can be best met in relation to hospital and specialty care.*

Lurie, Nicole, Janice Blanchard, and Matthew Mandelberg, "Access and Quality in D.C.: Are We (Still) Making Progress?" D.C. Primary Care Association, Medical Homes D.C. [presentation slides, undated].
*Presentation slides analyzing and mapping data on access to care, chronic disease burden, avoidable hospitalizations, and other indicators useful for policy decisions.*

Nicole Lurie, Martha Ross, and Allison Coleman, "Assessing the Primary Care Safety Net Needs and Health Disparities," D.C. Primary Care Association, Medical Homes D.C., January 28, 2005 [presentation slides].
*Presentation slides on the need and supply of medical care in the District, the conditions of District health centers' facilities, and the financial and planning capacity of health centers to expand or renovate these facilities.*

Stroudwater Associates, "50-Bed Safety Net Hospital for the District of Columbia; Overview of Estimated Project and Operating Costs," March 2005.
*Brief overview of the estimated initial project costs and annual operating costs of a fifty-bed safety net hospital.*

"Ambulatory and Urgent Care: What's the Difference?" Task Force staff extracts from online definitions of terms. [undated]
*Brief overview of the differences among various types of ambulatory care.*

"Data Guide," compiled by D.C. Primary Care Association. Distributed June 20, 2006.
*Provides a map and list of Medicaid MCO providers, as well as a map and list of D.C. Healthcare Alliance providers. The documents are current but undated.*

"Health, Demographic and Health Center Information by Zip Code," compiled by D.C. Primary Care Association. Distributed June 20, 2006.
*Tables presenting health, demographic, and health center information by Ward and zip code. The data are current but undated.*

"Private primary care providers that see both Medicaid MCO and Alliance patients, by zip code," compiled by D.C. Primary Care Association. Distributed June 20, 2006.
*Provider listing with map; current but undated.*

### Meeting 8: June 27, 2006

Handout, "Status of Tobacco Financing," June 27, 2006.

*The District of Columbia Certificate of Need Program: A Primer on Project Review*, District of Columbia, Department of Health, State Health Planning and Development Agency, Certificate of Need Review Division.
*Describes the project review process, who needs a Certificate of Need, how one is obtained, and how applications for review are judged.*

CON Review Requirements, Criteria and Standards, *District of Columbia, Department of Health, State Health Planning and Development Agency,* Certificate *of Need Review Division.*
*Reviews the six health systems characteristics used by the State Health Planning and Development Agency in analyzing Certificate of Need applications. These are need, accessibility, quality, acceptability, continuity, and financial viability.*

*Mayor's Health Care Task Force Alternate Options Combinations: DRAFT*, Department of Health for the Mayor's Health Care Task Force, June 27, 2006.
*Discussion draft of alternative options as charged by the Mayor or submitted or discussed by Task Force members.*

DISCUSSION DRAFT: National Capital Medical Center and Alternatives, Mayor's Task Force Illustrative "Packages" of Options, Urban Institute spreadsheet for the Mayor's Health Care Task Force, June 27, 2006.
*Discussion draft of examples of combinations of options to facilitate the Task Force's fulfillment of the Mayor's charge.*

### Meeting 9: July 11, 2006

*The National Capital Medical Center and the District's Need for Hospital-Based Emergency Department Capacity*, July 7, 2006.
*Document discussing Hospital Emergency Department overcrowding, Emergency Department boarders, and diversion in relation to the District Emergency Care System.*

*NCMC's Commitment to the Under-Insured, Uninsured and Vulnerable Populations*, distributed by Howard University to the Mayor's Healthcare Task Force, July 11, 2006.
*Presents the National Capital Medical Center's proposed plan to address the health care needs of the medically underserved populations in the District.*

*The Economic Impact of the National Capital Medical Center*, prepared by the Lewin Group.
*Estimates the regional impact of the National Capital Medical Center on the District's economy.*

*National Capital Medical Center: Defining the Need, Size and Scope*, prepared by the Lewin Group for Howard University, updated October 2004.
*Market, demand, and financial analysis to develop a plan for the National Capital Medical Center that defines the size, scope, and magnitude of costs.*

*Hospital Emergency Departments: Crowded Conditions Vary among Hospitals and Communities*, General Accounting Office GAO-03-460, March 2003.
*Provides findings of a GAO study investigating emergency department crowding, the factors contributing to crowding, and actions taken by communities and hospitals to address crowding.*

*Responding to Emergency Department Crowding: A Guidebook for Chapters*, a report of the Crowding Resources Task Force, American College of Emergency Physicians, August 2002.
*A resource guidebook for emergency physicians confronting Emergency Department crowding.*

*The Evolving Role of Hospital-Based Emergency Care*, National Academy of Sciences/Institute of Medicine Excerpts, (no date).
*Overview of the increasing demands on hospital emergency departments, the problems that this creates, and the impact this has on individuals.*

## Documents Distributed by Task Force Members

Michael Barch, Vanessa Dixon, and Victor Freeman, "Enhanced NCMC Model," undated (distributed June 20, 2006).

Colene Daniel, "Investment Related to Patient Care Services Impacted and Required in Wards 7 and 8," Greater Southeast Community Hospital, undated (distributed June 20, 2006).

Robert A. Malson, "Mayor's Health Care Task Force, Alternative Health Care Recommendation: Three Ambulatory Care Centers," June 19, 2006, accompanied by reprint of "ERs Swamped Despite New Beds and Strategies," by Susan Levine and Fredrick Kunkle, Washington Post, June 18, 2006, p. C01 (distributed June 20, 2006).

Michael C. Rogers, "Proposal to Advance Health Care and Health Status for Residents of the District of Columbia," 19 June 2006 (distributed June 20, 2006).

Eric Rosenthal, "A Healthy Washington," June 19, 2006 (distributed June 20, 2006).

Richard N. Wolf, "Choices on Medical Care Facilities: Mayor's Healthcare Task Force," undated (distributed June 20, 2006).

Victor Freeman, "EMS Recommendations," undated (distributed June 27, 2006).

-----, " 'Eastern D.C.' Health Issues are NOT just East of River Issues," undated (distributed June 27, 2006)

-----, "What does it take to Convert a Community Hospital Into a Level II Trauma Center...???," undated (distributed June 27, 2006).

-----, " 'Drop Time' Delays: DC Ambulances Stacking up at DC Hospital EDs. . .," undated (distributed June 27, 2006).
-----, "Meeting the Mayor's Health Care Task Force Charges," undated (distributed July 11, 2006).

## Presentations

*District of Columbia: Health Status, Trends and Risk Behaviors*, John Davies-Cole, Bureau of Epidemiology and Health Risk Assessment, D.C. Department of Health.
*Baseline Health Assessment of Low-Income D.C. Residents*, Sara Rosenbaum, Department of Health Policy, George Washington University School of Public Health and Health Services.
*Influence of Health Services and Other Factors on Health*, Randall Bovbjerg, Health Policy Center, The Urban Institute.
*Trauma Resource Allocation—Policy Issues and TRAMAH Model*, Charles Branas, Department of Epidemiology, University of Pennsylvania.
*District of Columbia State Health Plan*, Mark Legnini, Healthcare Decisions Group.
*Public Health Solutions to Urban Health Problems*, Steven Woolf, Virginia Commonwealth University.
*Recap: Summary of Needs and Priorities, Next Steps*, Randall Bovbjerg and Barbara Ormond, Health Policy Center, The Urban Institute.
*Emergency Medical Services in the District*, Amit Wadhwa, D.C. Fire and Emergency Medical Services.
*National Capital Medical Center*, Barbara Ormond, Health Policy Center, The Urban Institute.
*Medicaid DSH Program: Current Structure and Opportunities for Change*, Teresa Coughlin, Health Policy Center, The Urban Institute.
*Greater Southeast Community Hospital—Sustainable, Quality Health Care*, Colene Daniels, Doctor's Community Hospital Greater Washington, D.C., region, and Pedro Alfonso, Greater Southeast Community Hospital.
*Howard University and the National Capital Medical Center*, Victor Scott, Howard University.
*Status of Tobacco Financing*, Marcy Edwards, D.C. Office of the Chief Financial Officer.